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Stigma and Social Stressors Associated with Female Suicidal Behaviors in Lahore Pakistan

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Abstract

Objective

This study aimed to determine the prevalence of suicidal ideation and attempts among women of reproductive age and examined their association with mental illness, as well as socioeconomic and cultural factors. The research also seeks to contribute to the de-stigmatization of women's suicide, promote effective coping mechanisms, and strengthen the role of service providers in the prevention of suicide and attempted suicide in this population.

Methodology:

The study used a qualitative exploratory research design. This study was conducted at three tertiary-care hospitals of Lahore. By using purposive sampling, 15 female participants who had attempted suicide attempts, deliberated self-harm and suicidal ideations, and 5 services providers serving at the tertiary care hospital of Lahore were selected and interviewed. A semi-structured interview guide was developed and used to conduct the in-depth individual interviews..

Results

The findings showed a strong correlation between social determinants such as poverty and increasing rates of suicide among women of reproductive age. The direct relationship between suicide and mental illness was not found, however, social stressors were contributing to the development of mental illness, particularly depression and anxiety, among women. Social support was associated with a lower risk of suicide attempts among women. No positive role of the health system was identified in this study. According to service providers, factors like convergence of socioeconomic hardships, gender disparity and health system gaps are the causes of suicide among Pakistani women.

Conclusion

The study found that while social support was protective, poor family dynamics and social stressors were major contributors to suicidal behavior among women of reproductive age. The limited role of the health system highlighted gaps in prevention, emphasizing the need for policy development, improved suicide surveillance, and strengthening institutional support.

Introduction

Suicide is a critical world public health problem, and the World Health Organization (WHO) estimates that about 700,000 deaths each year occur globally (Mental Health, Brain Health and Substance Use (MSD), 2021). Suicide has been generally described as the intentional taking of one's life, mainly because of unbearable emotional distress, social stress, or hopelessness (Huizen, 2021). It is not a problem that results from one factor, but the product of a multifaceted interaction of psychological, social, cultural, and environmental determinants. Suicide is a global phenomenon, but its forms and risk factors differ in societies based on prevailing cultural norms, gender relations, and availability of healthcare services. It is also generally documented that the strongest risk factor for suicide is a previous attempt (Humayun, 2022). Evidence exists to indicate that although men kill themselves more frequently, women attempt suicide in disproportionate numbers at higher levels, which indicates the specific vulnerabilities, disadvantages, and social pressures they face (Bommersbach et al., 2022).

Suicide in Pakistan is a very sensitive and under investigated issue. The country does not have an effective national suicide surveillance system in place, and suicidal behavior is criminalized under the Pakistan Penal Code. This criminalization, along with stringent religious and cultural taboos, makes reporting problematic and results in serious underreporting of suicide rates (Raza, 2019). WHO estimates put the rate of suicide in Pakistan at 8.9 per 100,000 population for 2019, while the actual number is estimated to be much higher. In women, the situation is also compounded by gender-specific disadvantages that include truncated autonomy, vulnerability to domestic violence, early and forced marriages, narrow social mobility, and limited access to mental health care (Shekhani et al., 2018).

Despite this dire situation, the majority of studies on suicide in Pakistan are based on quantitative data, which does not reflect the complexity and lived realities of suicidal behavior. Such approaches tend not to tap into the cultural situation, individual issues, and structural inequalities that drive women into suicidal ideation and attempts. On the other hand, qualitative research allows one to delve into the voices of the women who have encountered such issues in depth so that the intersection between the individual distress and societal limitations may be better understood.

This study attempts to bridge this gap by assessing the impact of stigma, gender inequality, and social determinants of stress on female suicidal behavior in Lahore. By centering women's suicide attempt stories, it hopes to lay bare how cultural silence, patriarchal norms, and institutional neglect intersect to produce conditions of despair. The results seek to inform healthcare providers, policymakers, and community members to develop culturally sensitive interventions that target not just the psychological aspects of suicide but also the broader socio-cultural and gender-based constraints that construct women's lives.

Literature Review

The following describes the body of literature on suicide and suicidal thoughts among women of childbearing age in Pakistan, including the relationship between mental illness, socioeconomic, cultural, and religious determinants of suicide, as well as the role of legislation and service providers in managing this public health concern.

Global Overview of Suicide

Suicide is an act of self-inflicted fatality that is done with the purpose of dying (Glodsmith et al., 2002). Suicide is identified as a serious international public health issue and takes about 700,000 lives every year (Fevre, 2014). Suicide is not geographically or demographically isolated; suicide impacts people from all cultures, sexes, social strata, and beliefs. Among youth, it continues to be especially alarming, ranking as the fourth biggest cause of death among those between 15 and 29 years old across the globe. Various factors such as cultural norms, economic challenges, and mental illness all come together to make one vulnerable to suicide (Suicide in the world: Global Health Estimates, 2019).

Suicide in Developed Countries

In developed nations, suicide has become one of the top causes of premature death. In the United States, it is the second most prevalent cause of death among the age group of 10–34, which shows its disproportionate effect on younger groups (Suicide worldwide, 2021). In the United Kingdom, determinants like drug abuse, violence against children, sexual violence, and depression have been strongly linked with suicide. Concerningly, suicides among the youth population in the UK and Ireland continue to be high, with 6,800 cases reported in 2019 (Nasir, John & Shellard, 2021). Increasing trends observed in England and Scotland at 12–14% indicate that socioeconomic disparity is the leading force (Iacobucci, 2020).

Suicide in Developing Countries

The suicide burden in developing nations is also compounded by systematic underreporting and legal restrictions. Suicides in nations such as India exceed 150,000 every year, with alarming rises in teenagers and students (Sharma & Harikishan, 2021; Nye, 2022). In South Asia, child marriage, poverty, and gender discrimination strengthen the issue. Unavailability of proper reporting channels based on religious or cultural insensitivity results in huge underestimation of true suicide rates.

Suicide in Pakistan

Suicide in Pakistan is both a social taboo and a public health issue. WHO has approximated the crude suicide rate in 2019 as 8.9 per 100,000, although underreporting is a significant limitation with cultural, legal and religious constraints. Although men are reported more often in suicidal statistics, researchers contend that stigma and legal consequences bring about more hiding of female suicides. Research has proven that women from rural parts such as Chitral have close to double the rate of suicide compared to men, with pressures due to marriage and forced early marriages being major push factors (Hussain et al., 2019).

Suicidal Behavior among Women

Suicidal behavior encompasses ideation, planning, attempts, and completed suicides. Women, particularly in developing nations, have specific vulnerabilities. Suicidal behavior in Pakistan is very stigmatized, restricting disclosure and studies (Chotani, Razzak & Luby, 2002). Illiterate women, those coerced into early marriage, and those subjected to domestic violence are among the most vulnerable (Ahmed et al., 2016).

Methods of Suicide in Women

Suicide methods worldwide have been reported as hanging, poisoning, and use of firearms. In Pakistan, poisoning with pesticides and over-the-counter drugs such as benzodiazepines is found to be the most prevalent method, indicating easy accessibility and absence of control. Rural women disproportionately use organophosphorus poisoning due to agricultural exposure (Khawaja, Majeed & Malik, 2005).

Conditions Linked to Female Suicide

Mental illness, especially depression and anxiety, is closely linked to suicidal thoughts among Pakistani women. Research shows alarming levels of depression, with almost 57.5% of women being infected). Socioeconomic difficulties, such as poverty, dissatisfaction with marriage, and domestic abuse, also intensify the danger (Ali, Mogren & Krantz, 2013).

Gender subordination is also supported by cultural norms with women required to adhere to patriarchal family roles and limiting autonomy and inducing psychological distress. Religious tenets, criminalizing suicide in Islam, further exacerbate stigma and underreporting, while legal statutes still regard attempted suicide as a crime, thus discouraging healthcare-seeking actions (Arafat et al., 2021).

The literature demonstrates a compelling overlap between mental illness, socioeconomic deprivation, cultural subordination, and legislative barriers in influencing female suicide in Pakistan. While the world's developed countries focus on mental health interventions, Pakistan's reality points to structural inequities, violence against women, and a fragile health system. One of the chief challenges is the underreporting of suicides as a result of legal and

cultural restrictions, which compels a misleading view of the prevalence of the problem and discourages evidence-based policy-making. Female suicide in Pakistan therefore demands a multi-dimensional solution, incorporating mental health interventions, socio-economic empowerment, gender equality reforms, and suicide decriminalization.

Methodology

The research used a qualitative study design to examine suicide and suicidal behavior among reproductive-aged women in Lahore, Pakistan. Lahore was chosen due to its large diverse urban population and accessibility to healthcare institutions and support services relevant to suicide-related cases. The aim was to study the contribution of mental illness, socioeconomic factors, and culture as predictors of female suicide, as well as the contribution of the healthcare system and service providers towards prevention.

Study Setting

The study was carried out in three tertiary healthcare hospitals of Lahore: Jinnah Hospital, Sir Ganga Ram Hospital, and Services Hospital. Data were gathered from the Departments of Psychiatry and Behavioral Sciences and the Emergency and Trauma Centers of the aforesaid hospitals.

Study Population and Sampling

Purposive sampling was utilized for selecting suitable study participants. The population for the study consisted: 15 reproductive-age female patients with suicidal ideation (in the past 1–2 years), self-injurious behavior, or suicide attempts and 5 health service providers (clinical psychologists, psychiatrists, and medico-legal officers) with experience of at least five years in handling such patients. Male patients, non-reproductive-age females, and patients with long-standing mental illnesses were excluded. The service providers of tertiary care hospitals with no experience in dealing with patients with deliberate self-harm and suicide ideation were excluded from this research.

Data Collection

Data were collected using two different semi-structured interview guides: one for service providers and one for female patients. Informed consent was obtained from the study participants and they had liberty to participate/leave study at any part of the data collection. Anonymity and confidentiality of data was ensured and consent was also obtained to record the interviews. Interviews were held in Urdu and Punjabi, lasting 30–35 minutes, to achieve the data saturation. Open-ended questions enabled the participants to narrate their experiences with special focus on delicate issues like domestic violence, forced marriage, sexual harassment, financial strain, and mental illness.

Data Analysis

Thematic analysis was used to examine the qualitative data in accordance with Braun and Clarke's six-step method. Initially, the researchers read the interview transcripts several times to become familiar with the data. Second, initial codes were systematically generated from meaningful segments of the data. Third, these codes were collated into potential themes by identifying patterns across participants' narratives. Fourth, in order to guarantee internal coherence and consistency with the complete dataset, the themes were examined and refined. Fifth, the themes were clearly defined and named to capture their core meaning. Finally, the analysis was reported through a coherent narrative, supported by illustrative verbatim quotations and linked to the study objectives and existing literature.

Ethical Considerations

Ethical clearance was granted by the Doctoral Program Coordination Committee (DPCC), University of Punjab, Lahore. Written consent was also obtained from medical superintendents and directors of psychiatry departments of the selected hospitals. All the participants provided informed consent, were assured confidentiality and anonymity, and were apprised of their right to withdraw at any point in time. Pseudonyms were employed during analysis for safeguarding participants' identities. Human Ethics and Consent to Participate attained from the participants.

Findings

The present research ventured into the explanations of women's suicidal behavior, intentional self-harm, and suicidal thoughts in Pakistan, in addition to the views of healthcare professionals. Fifteen female patients and five service providers were interviewed. Thematic analysis produced three overarching themes: 1) suicide as a socioeconomic problem, 2) suicide as a mental health problem, and 3) the role of the healthcare system in suicide prevention.

Table 2
Emergent Themes

Sr. No	Main Themes	Subthemes
1.	Suicide as a Socioeconomic Issue	Family dynamics, Violence, Economic Issues, Cultural/gendered Issues, Social support
2.	Suicide as a Mental Health Issue	Mental illness, Stigmatization of suicide
3.	Role of Service Providers in Suicide Prevention	Treatments for Suicide Reduction, Challenges in Prevention of Suicide

Sociodemographic Profile of Participants

Participants consisted of fifteen women ranging in age from 18 to 35 years, of whom 8 participants belonged to the younger age group of 18–25. The majority were married, housewives, and came from nuclear family systems, representing the common demographic of young Pakistani women who are subjected to social and familial pressures. Of the fifteen, seven had made suicide attempts, four had practiced intended self-harm, and four presented with recent suicidal thoughts. The most prevalent means were drug overdose and self-harm through cuts, similar to patterns seen in South Asian suicide research (Anjum et al., 2020).

With the exception of one Christian woman, all participants were Muslim, demonstrating the cultural homogeneity of the study. Most reported being financially dependent on parents or husbands, emphasizing their lack of economic independence. Service providers were psychiatrists, clinical psychologists, and emergency doctors from tertiary hospitals, providing a professional input.

This portrait captures the ways in which sociodemographic risks—adolescence, marriage-related stress, economic dependency, and nuclear family status—converge with psychosocial variables to generate women's suicide risk. It also highlights that understanding suicide not as a lone event, but as strongly rooted in social organization, is crucial.

Table 1
Demographic profile of participants

Characteristics	No. of Participants (N = 15)
Gender	**15**
Female	
Religion	**14**
Islam	**1**
Christianity	**0**
Others	
Age	8
15–25	4
26–35	1
36–45	2
46–55	0
56–65	0
Above	
Years of Education	1
Nil	1
Primary	2
Secondary	4
Matriculation	1
Intermediate	3
Bachelors	3
Masters	
Marital Status	8
Married	6
Unmarried	1
Divorced	0
Widowed	0
Others	
Children	6
Yes	9
No	
Employment Status	3
Employed	8
Unemployed	4
Student	0
Others	
Household Income	1
Less than 10,000	3
10,000–25,000	4
26,000–40,000	1
41,000–55,000	6
Above	
Husband's Employment Status	6

Characteristics	No. of Participants (N = 15)
Gender	**15**
Female	
Religion	**14**
Islam	**1**
Christianity	**0**
Others	
Employed	3
Unemployed	6
Participant not married	
Family System	10
Nuclear (single family)	5
Joint family system	
Residence	9
Owned	6
Rented	
Type of Harm	7
Attempted Suicide	4
Deliberate self-harm	4
Suicide Ideations	
Methods of suicide	4
Medicine overdose	4
Cuts	0
Poisoning	0
Hanging	3
Self-torture	1
Multiple Methods	3
Nothing	

Theme 1: Suicide as a Socioeconomic Issue

Socioeconomic difficulties were a central motivator of suicidal behavior. Poverty, marital difficulties, social stigmatization, and overly rigid family life repeatedly found their way into participants' narratives. Research bears out that persons from lower socioeconomic status are at a greater risk of suicide because of ongoing stress and few resources to cope (Raschke et al., 2022).

A clinical psychologist underscored this relationship:

"Mental illness has a huge role in suicide… But in nations like Pakistan, the majority of mental illnesses like depression or panic attacks arise from social stressors, or they emerge in response to socioeconomic stressors."

This echoes the biopsychosocial model, in which mental illness is defined by both biological susceptibility and socioeconomic disadvantage. In contrast to biomedical accounts, this account locates suicide within structural disadvantage and thus as a social, not individual, issue.

Family Dynamics and Relationships

Family, as a supposed source of protection, too often operated as a source of distress. For married women, marital neglect and abuse were prime precipitants:

As participant (P1) said: "Had liked this cousin of mine… Slapped me twice… Had imagined that if my parents would ever have to take care of my duty after marriage, they wouldn't have married me here at all."

This demonstrates the role of marital conflict and gendered expectations in intensifying feelings of worthlessness. Women internalize responsibility for relationship breakdowns, which is a reflection of patriarchal socialization that imposes responsibility on women for conjugal stability.

Marital relations were similarly rooted in conflict:

As participant (P2) said: "My mother-in-law claims that I am a shame (Kalay Muu wali)… She destroyed my fifteen years of marriage."

Such accounts are consistent with findings that women in joint households frequently experience emotional abuse, control, and stigmatization, resulting in fewer options of support (Anjum et al., 2020).

Likewise, childhood trauma and parental neglect influenced participants' vulnerability:

Participant (P3) said: "My step-sisters abused me. My mother always believed the step-sisters and ignored me… Before she passed away, she knew that I was being subjected to violence… but it doesn't matter because what has been done is done."

This shows the long-term effect of deprivation in childhood on adult mental well-being. Even belated acknowledgment by carers cannot reverse years of psychological harm.

Sexual and Domestic Violence

Sexual and domestic violence were both chronic causes of suicidality. Participants 4 and 5 had reported child sexual abuse:

Participant (P4) said: "I have been sexually abused as a child and that was my trauma and it haunts me to this day… I am better now, and I have control over my life now."

Her story shows how early trauma translates into lifetime vulnerability. Notably, she also identified prevention:

Participant (P5) said: "Parents don't typically know… I believe parents should keep an eye on their relatives when they are left alone with their children."

This is a telling expression of a fundamental structural failure in child protection in Pakistan, where silence within the family allows for abuse to prevail. Domestic violence, especially verbal and physical abuse by husbands and in-laws, was also commonly reported, corroborating international evidence that gender-based violence is one of the major determinants of suicide amongst women.

Social Support as a Protective Factor

In spite of adversity, numerous participants emphasized the life-saving function of social support. Friends and siblings were regularly portrayed as hope anchors:

Participant (P5) said: "My friends always listen to me… They supported me a lot… They make me understand what is good for me and what is bad."

Participant (P6) said: "My brothers are my very close friends… My family helped me a lot to cope with my mother's death."

These stories validate that support networks keep despair at bay. Yet such support was not equitable; numerous women felt isolated, and the importance of evidence-based peer-support interventions was indicated.

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Gender Disadvantages

Gender disparity was another resurfacing factor. Women reported being deprived of education and forced to marry early:

Participant (P7) said that: "My parents denied me to pursue my studies and married me. My husband does not have a fixed job. My brother-in-law attempted to harass me… I frequently feel that perhaps if I had completed my studies, I would have assisted my husband during times of financial crisis."

Her contemplation illustrates how education denial diminishes women's economic autonomy, increasing vulnerability. According to one psychologist:

"The social or gendered aspects of our society are working towards women's suicides… still, here, most women lack freedom to express themselves."

This is consistent with evidence that gender disadvantage, from son preference through to limited mobility, increases suicide risk (Qadir et al., 2011).

Theme 2: Suicide as a Mental Health Issue

While economic and social pressures were ubiquitous, psychiatric disorders—most notably depression, anxiety, and PTSD were cited as direct causes of suicidal thinking. International literature establishes depression as the top psychiatric predictor of suicide.

One psychologist explained:

"If we discuss depression, the central symptom of depression is suicidal ideations… But these diseases tend to be caused by psychosocial stressors."

This attests that mental illness is not isolatable from social situations. Several participants reported stories of panic attacks, impulsive acts, and self-harm:

"I began experiencing suicidal thoughts… I torched the mattress and remained in the room to see it burn."

These attacks demonstrate emotional dysregulation and inaccessible psychiatric care, with a resulting amplification of crises.

Stigma and Suicide

Stigma related to mental illness and suicide came up as one of the hindrances to care. Participant 6 illustrated her brother's contribution towards avoiding stigma:

"These individuals who say that you are fool or crazy, actually they are fool and crazy… They should be treated for mental issues, not you."

This serves to illustrate how family advocacy and reframing can work against stigma (Rüsch et al., 2009). But numerous women did not have such support, which shows that anti-stigma campaigns need to be done in suicide prevention.

Theme 3: The Health System's Role in Suicide Prevention

The third theme concerns systemic issues and the depleted capability of Pakistan's health system. Although providers acknowledged the requirement for integrated, biopsychosocial care, structural limitations circumscribed effectiveness.

A provider summed up:

"When we speak of the biopsychosocial model, we speak of genetics, social stressors, and depression and anxiety problems… financial stressors are the drivers of people towards suicide and self-harm."

This indicates awareness but also shows systemic limits overcrowded hospitals, lack of specialists, and no suicide-specific services. Additionally, preventive services are limited, so intervention tends to happen after a suicide attempt.

These findings identify that suicide among Pakistani women as a phenomenon with multiple factors, influenced by the convergence of socioeconomic adversity, gender disadvantage, psychiatric morbidity, and health system gaps. The narratives of women show how trauma and intrafamilial conflict create desperation and how stigma and poor health systems are ineffective in giving relief. Concurrently, supportive relationships were identified as protective and point towards avenues for community-based interventions. Suicide prevention, thus, calls for coordinated interventions targeting both the structural disparities and the psychological aspirations of women.

Discussion

This research explored how socioeconomic, mental health, and cultural variables intersect in the histories of women who had tried suicide, engaged in recurrent self-injury, or had suicidal ideation. Our interviews revealed that strain within family systems was universal: nine interviewees reported severe family crises, and those crises frequently co-occurred with post-traumatic stress, anxiety, depression, and panic symptoms. In line with this trend, family conflict, domestic violence, and limited social support followed closely with the onset or exacerbation of mental disorders, while parental and more general social support unequivocally buffered risk. Meanwhile, participants' and providers' narratives pointed up service delivery gaps and policy incoherence, suggesting prevention needs to involve not only clinical interventions but systems-level and cross-sectoral action.

Suicide as a Socioeconomic Issue

Pakistan's structural lag—lagging regional neighbors on major social indicators—sets the stage upon which individual distress plays out. Poverty, joblessness, discrimination, injustice, and declining social cohesion have all been implicated in increasing suicidality (Shahid & Hyder, 2008). Our own data replicate these macro-level findings at the micro level: women who found themselves located in financially dependent positions within patriarchal, closely monitored family arrangements reported feeling trapped, publicly condemned, and privately isolated.

A self-critique of certain women-only suicide scholarship is in order: previous work has sometimes pathologized "feminine nature" but silenced social arrangements generating risk (Mallon, 2016). Our results dispel dispositional accounts. That is, participants recounted marital conflict, criticism by in-laws, and ongoing invalidation as precipitators. This is in line with evidence that family environment factors—parental psychopathology, conflict, loss, and maltreatment—are strong risk factors for adolescent suicidality, and with the suggestion that familial clustering of suicidal behavior can be a result of both genetic and environmental transmission, and not biology.

Poor family cohesion and low flexibility have been related to increased suicide risk. Our sample's age profile harmonizes with that of the nation: Pakistani suicides predominantly take place under the age of 30, with women's rates relatively elevated (Naveed et al., 2017). Accounts by our participants of verbal and physical spousal and in-law abuse, and two reports of sexual abuse, are in harmony with research describing gender-based violence as a proximal cause of suicidal thoughts and behaviors. Evidence-based interventions—such as trauma-focused CBT in sexually abused women and enhanced reporting/response channels—alleviate symptom burden and may break patterns toward self-injury. These, however, rely on access, knowledge, and trust, which many of our interviewees did not possess.

Social connectedness was a protective counterbalance. However, seven of fifteen women reported isolation, judgment, loss of belonging, and diminished support, all identified risk factors for suicidal behavior and thought. Interestingly, interpersonal support in heterosexual relationships is still asymmetrically gendered: wives are more likely to be supportive when husbands are under pressure, but reciprocation is not guaranteed when wives are under pressure. This imbalance goes some way to explaining why even "intact" families may be psychologically unsafe for women.

At the social level, loneliness and isolation are still under-addressed public issues. Primary prevention has the potential to invest in positive family communication skills, social protection to buffer poverty, and community peer-support networks—well-documented upstream levers in light of the link between low income/unemployment and self-harm in lower-middle-income contexts such as Pakistan (Bachmann, 2018).

Suicide as a Mental-Health Issue

One of the longest-standing debates in low- and middle-income countries (LMICs) often revolves around whether social adversity or mental illness is the stronger driver of women's suicide. Some contend social and economic pressures are the leading drivers, and that whatever physiological contribution is present must be filtered through role expectations and context. Our evidence indicates this is a false dichotomy. The participants' depressive, anxious, and post-traumatic symptoms were highly interwoven with chronic invalidation, intimate-partner conflict, and economic precarity. That is, social stressors and mental disorders co-produce risk.

Clinically, depression is still a key warning sign: although the majority of depressed people do not die by suicide, higher depressive severity increases risk. Claims of panic attacks, suicidal self-injury, and intrusive trauma recollections in this population illustrate emotion dysregulation under chronic stress. The implication is pragmatic: preventing suicide in LMICs needs to treat disorders and change contexts—screen and treat depression, anxiety, and PTSD and reduce the family-level relationships and socioeconomic stress that keep re-injuring recovery.

The Health System's Role in Suicide Prevention

Providers and participants agreed on the necessity for multi-level, integrated prevention. Global best practice promotes systemic approaches that integrate community-based services with hospital-based care and stress cross-sector collaboration (Naz et al., 2016). Implementation, however, assumes availability of data. Evidence from Nepal demonstrates that without authoritative statistics and harmonized reporting across legal, social, cultural, and medical systems, prevention grinds to a halt. Pakistan is similarly constrained: under-reporting, stigmatization, and legal sensitivities deflect the problem's true size.

Within the health system, chronic capacity and governance deficits hold back response: quality deficits, management shortcomings, stock-outs, disengagement of workers, and incentives out of alignment are all commonly reported (Kurji, Premani & Mithani, 2016). Mental-health personnel are most in short supply—there is one psychiatrist for ~ 10,000 patients and one child psychiatrist for ~ 4,000,000 mentally ill children (Khan et al., 2016). These limitations result in the prevention of even attempted-suicidal-patient presentations following self-harm from being taken advantage of as opportunities for risk assessment, safety planning, brief psychosocial intervention, and active follow-up. A realistic way forward is: standardized suicide-risk protocols for emergency and outpatient care; brief, scalable psychotherapies; robust referral and follow-up pathways; and formal connections between hospitals, social welfare, protection services, and community organizations.

Considered holistically, the evidence argues in favor of a dual-focus model: women's suicidality in Pakistan is constructed at the nexus of social structure and psyche. Family discord, power inequities of a gendered sort, and economic dependence are not ambient noise—these are active ingredients in the causal recipe. Depression, anxiety, PTSD, and panic are both symptoms of these conditions and proximal causes of suicidal impulses. Prevention must be brought together: reduce poverty and boost social protection; prevent and respond to gender violence; develop family communication and conflict-resolution skills; scale up mental-health coverage with scalable, trauma-sensitive care; establish anti-stigma and help-seeking pathways; and repair basic health-system bottlenecks through training, protocols, and cross-sector coordination. In short, women do not kill themselves because of "who they are,"

but because of what has been done to and withheld from them—safety, dignity, autonomy, resources, and care. Any serious prevention agenda must return these.

Limitations

This research has several limitations that need to be recognized. Firstly, the study involved only female participants, excluding male participants, so the generalizability of the findings is limited. Secondly, the sample size was somewhat small (15 female participants and 5 service providers), so it may not reflect the full range of experience across various social and cultural contexts in Pakistan. Third, the research was limited to dissertations presented at these hospitals in Lahore and hence is less generalizable to private healthcare centers or rural settings. Fourth, there was no follow-up with participants after interviews that limited understanding of the long-term effect of suicidal ideation and attempts by them. Fifth, because of the sensitive nature of the research, some participants might not have shared or underreported some experiences, resulting in response bias.

Conclusion

This research examined the multifaceted issue of female suicides in Pakistan and the intertwined role of socioeconomic factors, mental health issues, family patterns, and the healthcare service providers. In the tertiary care hospitals of Lahore, namely Jinnah Hospital, Sir Ganga Ram Hospital, and Services Hospital, a sample of 15 women of reproductive age with attempted suicide, self-inflicted injury, and suicidal thoughts and five healthcare providers were included.

The results indicated that marital discord, tense family relationships, in-laws' physical and verbal abuse, and poor parent-child relationships were all chronic risk factors for suicide. Socioeconomic factors such as poverty, social isolation, and absence of supportive social networks further exacerbated psychological distress symptoms, which came in the form of depression, anxiety, PTSD, and panic disorders. As the international evidence suggests, this study established that social support is a vital buffer that immensely lessened suicidal ideation as well as suicidal attempts.

The health system's contribution to preventing suicide, nonetheless, was poor. Public hospital psychiatry wards continue to be under-staffed with excessive use of medication and little in the way of counseling or psychosocial treatments. Clinical psychologists are few in number and follow-up mechanisms for those at high risk are almost nonexistent. To add to this, suicide continues to be under-reported and stigmatized, so that planning and implementing effective prevention programs is challenging.

The research points out that suicide prevention among women is an inter-sectorial task. The functioning of the family needs to be strengthened via education, communication skills training, and early recognition of distress. The health system needs to put mental health services first, increase psychological support, and implement cross-sector collaboration. There also needs to be increased societal effort to minimize stigma, improve reporting, and tackle structural inequalities that perpetuate women's vulnerability. By situating suicide in the cultural, economic, and social context of Pakistan, this research offers evidence for creating more effective, culture-sensitive prevention plans.

Recommendations

To effectively address female suicide in Pakistan, a multipronged approach is needed. At the policy level, a 24-hour national suicide prevention helpline should be established, alongside awareness seminars in schools, universities, workplaces, and hospitals, as well as nationwide social and media campaigns to reduce stigma and promote help-seeking. Hospitals should distribute educational materials, while suicide reporting must be standardized across all facilities for better policymaking. Operationally, emergency departments should ensure that suicide attempt cases receive full psychiatric evaluation and not be discharged prematurely, while cross-sector collaboration with psychiatry, domestic violence services, and crisis centers should be strengthened. Psychiatric services need greater visibility, and both public hospitals and private clinics should expand and make care affordable. The media should adopt responsible reporting guidelines. Finally, more qualitative, female-focused, and methodologically sound research is essential, with findings directly informing gender-sensitive policies and suicide prevention strategies.

Declarations

Authors contributions: R.L(Rameesa Liaqat) participated in the idea conception, original draft preparation and develop the questionnaire also supervision. M.N.T(Muhammad Navid Tahir) participated in methodology, developing manuscript and formal analysis also visualization and A.R(Assia Riaz) participated in the proposal development, data collection and writing manuscript review, editing, also investigation. S.N.F (Syeda Nida Fatima) participated in writing manuscript, review, editing. I.J (Isha Javed) participated in the proposal development, data collection. All authors have read and agreed to the published version of the manuscript.

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Data Availability Statement

The datasets generated during and/or analysed during the current study are not publicly available due to the sensitive nature of qualitative interview data and participant confidentiality but are available from the corresponding author on reasonable request.

Ethical Approval & Accordance

Ethical clearance was granted by the ISCS Department, University of the Punjab, Lahore. The study was conducted in accordance with the Declaration of Helsinki and relevant institutional guidelines and regulations for research involving human participants.

Consent to Participate

Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were informed about the purpose of the research, confidentiality of their responses, voluntary participation, and their right to withdraw from the study at any stage without any consequences.

Consent to publish

All participants provided informed consent for the anonymized data to be published for academic and research purposes.

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